

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/20/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G535		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/23/2011	
NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1901 W GOLDEN HILLS DRIVE PERU, IN46970			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W0000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: September 20, 21, 22, and 23, 2011</p> <p>Facility number: 001049 Provider number: 15G535 AIM number: 100245300</p> <p>Surveyor: Tracy Brumbaugh, Medical Surveyor III</p> <p>These deficiencies also reflect state findings under 460 IAC 9. Quality Review completed 10/3/11 by Ruth Shackelford, Medical Surveyor III.</p>			W0000			
W0104	<p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the governing body failed for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) who lived in the home, to ensure the dining room floor remained in good repair.</p>			W0104	<p>The Social Service Coordinator will complete monthly inspections of the group homes ensuring that the house is in good repair. The inspection information will be forwarded to the Vice President of Residential Services and the maintenance department. The</p>		11/14/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0227	<p>Findings include:</p> <p>On 9-20-11 from 3:30 p.m. until 5:30 p.m. an observation at the home of clients #1, #2, #3, #4, #5, #6, #7, and #8 was conducted. At 3:30 p.m. the dining room floor laminate was observed to be warped and discolored over half of the dining room floor around the dining room table.</p> <p>On 9-21-11 at 1:00 p.m. an interview with the House Manager indicated the floor had been in need of repair for about a year.</p> <p>9-3-1(a)</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review, and interview, the facility failed for 1 of 4 sampled clients (client #2) to ensure his cussing and spitting was addressed in his Individualized Support Plan (ISP) or Behavior Support Plan (BSP).</p> <p>Findings include:</p> <p>On 9-20-11 from 1:30 p.m. until 3:00 p.m. an observation at the facility owned day program for client #2 was conducted.</p>			W0227	<p>maintenance department will complete what they are capable of and we will contract out other jobs. Estimates for new flooring have been obtained. We are in the process of picking out the color/style. The new flooring will be installed by 11/14/11.</p> <p>Client #2 has a new BSP in place. The plan has been approved by his guardian and HRC. The new plan has interventions in place to assist staff when Client #2 engages in spitting and cussing. Staff have been trained on the updated BSP. Staff will track the targeted behaviors. The QDDP will monitor the targeted behaviors for progression/regression.</p>		10/07/2011

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	<p>Throughout the observation client #2 was observed to spit on the table, the floor, and to use offensive language to the staff and other coworkers in his class room.</p> <p>On 9-20-11 at 2:25 p.m. an interview with day program staff #13 indicated client #2 did use foul language in the classroom and he did spit on the floor and table. Day program staff #13 indicated any change in client #2's routine caused these outbursts.</p> <p>On 9-20-11 from 3:30 p.m. until 5:30 p.m. an observation at the home of client #2 was conducted. At 3:45 p.m. client #2 was observed to spit on the dining room table and call the house manager an offensive name.</p> <p>On 9-21-11 at 9:00 a.m. a record review for client #1 was completed. The ISP/BSP dated 9-27-10 failed to address his foul language and spitting.</p> <p>On 9-21-11 at 1:00 p.m. an interview with the Qualified Mental Retardation Professional indicated spitting and foul language were not addressed in client #2's ISP/BSP and he did continue to display these inappropriate behaviors.</p> <p>9-3-4(a)</p>						

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W9999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rules were not met.</p> <p>1. 431 IAC 1.1-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by division.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to report timely to the Bureau of Developmental Disabilities Services (BDDS), 1 of 2 follow-up BDDS reports for 1 of 8 clients living in the home (client #6).</p> <p>Findings include:</p> <p>Facility records were reviewed on 9-20-11 at 11:35 a.m., including BDDS reports for the time period between 10-10 and 9-11. The BDDS reports indicated the following:</p> <p>- A BDDS report for an incident on 5-3-11</p>			W9999	<p>All QDDP's have been retrained on the importance of completing incidents and follow-ups in a timely manner. Follow-ups should be completed every 7 days until the incident is closed. All initial incident reports whether they are completed by day programs or residential along with follow-ups are sent to the VP of Residential Services. All incident reports are kept in one central location and monitored for patterns/tracking purposes.</p>		09/30/2011

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	<p>involving a fall with bruising and scrapes for client #6, indicated this report to BDDS was made on 5-3-11 with a follow up made to BDDS on 5-19-11.</p> <p>A review of the BDDS reporting policy dated 6-11-02 was conducted on 9-20-11 at 12:00 p.m. The policy indicated: "The party responsible for follow-up completes an on-site review within seven days to determine if the incident has been resolved."</p> <p>An interview with the facility Vice President of Residential Services was conducted on 9-21-11 at 1:00 p.m. She indicated BDDS follow up reports should be completed every 7 days until closed.</p> <p>9-3-1(b)</p>						